

Exhibit C



February 20, 2015

JOHN RAKIS
C/O MICHAEL BARASCH
BARASCH MCGARRY SALZMAN & PENSON
11 PARK PLACE 1801
NEW YORK NY 10007-2811

Dear John Rakis:

The Special Master has determined that you have been appointed as the Personal Representative for the claim filed on behalf of FREDDIE WALLACE-RAKIS and the September 11th Victim Compensation Fund ("VCF") will move forward with the review of your claim. The claim number is VCF0026520.

As the Personal Representative, you are responsible for submitting all materials necessary for the VCF to process the claim. This includes information and documents needed to determine the decedent's eligibility and to calculate the appropriate compensation under the terms of the Statute and Regulations.¹

The Personal Representative is also responsible for assuring that any compensation received from the VCF on behalf of the deceased individual is distributed to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master. Please see Frequently Asked Questions ("FAQs") #5.1 - #5.5 and #8.11 on the www.vcf.gov website for more information.

When submitting the Compensation Form for Deceased Individuals, you are required to propose a distribution plan. If there is a bona fide dispute over the proposed distribution plan, the Special Master is not required to arbitrate, litigate, or otherwise resolve any such dispute. In these situations, the Special Master will, if sufficient information is provided, calculate the appropriate compensation amount and authorize payment, but will hold any payment until the dispute is resolved. If the dispute cannot be resolved by agreement of the various parties, the Special Master may deposit the award into your account (as the Personal Representative) or into a court supervised account while the dispute is adjudicated by a court of competent jurisdiction.

The VCF will inform you if any additional documentation is needed in order to process your claim.

If you have any questions regarding your claim, please call the VCF toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100. Every effort will be made to respond to your application and/or inquiries as soon as possible.

¹ The Statute (the Air Transportation Safety and System Stabilization Act as amended by the Zadroga Act) and the Regulations are located at <http://www.vcf.gov/genProgramInfo.html>.



July 9, 2018

JOHN RAKIS
C/O MICHAEL BARASCH
BARASCH MCGARRY SALZMAN & PENSON
11 PARK PLACE 1801
NEW YORK NY 10007-2811

Dear JOHN RAKIS:

The September 11th Victim Compensation Fund ("VCF") sent you a letter on February 22, 2018 notifying you of the decision on your claim and the amount of your award. Your claim number is **VCF0026520**. That letter included a request for documents that were missing from your claim and are required in order to process your payment. The VCF has since received the requested documents and this letter provides the details of your award and information on the next steps to be taken on your claim.

Based on the information you submitted, the VCF has calculated the amount of your eligible loss as **\$462,750.19**. This determination is in accordance with the requirements of the Reauthorized Zadroga Act. The enclosed "Award Detail" includes a detailed explanation of the calculation and a list of the eligible conditions included in this determination.

No non-routine legal service expenses are approved for reimbursement for this claim.

As the Personal Representative, you are required to distribute any payment received from the VCF on behalf of the victim to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master.

What Happens Next

The VCF will deem this award to be final and will begin processing the payment on your claim unless you complete and return the enclosed Compensation Appeal Request Form within **30 days from the date of this letter** as explained below. If you do not appeal, the Special Master will authorize the payment on your claim within 20 days of the end of the 30-day appeal period. Once the Special Master has authorized the payment, it may take up to three weeks for the United States Treasury to disburse the money into the bank account designated on the VCF ACH Payment Information Form or other payment authorization document you submitted to the VCF.

- **Appealing the Award:** You may request a hearing before the Special Master or her designee if you believe the amount of your award was erroneously calculated or if you believe you can demonstrate extraordinary circumstances indicating that the award does not adequately address your claim. **If you choose to appeal, your payment will not be processed until your appeal has been decided.**



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To request a hearing, you must complete and return the enclosed Compensation Appeal Request Form and Pre-Hearing Questionnaire no later than **30 calendar days** from the date of this letter. The VCF will notify you in writing of your scheduled hearing date and time and will provide additional instructions to prepare for your hearing. If both forms are not submitted with complete information within 30 days, you have waived your right to appeal and we will begin processing your payment.

- **Amending your Claim:** You may amend your claim in the future if your circumstances change and you have new information to provide to the VCF. For example, you may amend if the WTC Health Program certifies additional physical conditions for treatment, if you have information in support of your claim that was not submitted to the VCF when your award was determined and that you believe would affect the amount of your award, or if you have incurred additional economic loss due to an eligible condition. The VCF will review the new information and determine if it provides the basis for a revised decision. Please see the VCF website for additional details on how to amend your claim and the specific circumstances that may be appropriate to request an amendment.
- **Notifying the VCF of new Collateral Source Payments:** You must inform the VCF of any new collateral source payments you receive, or become entitled to receive, such as a change to your disability or survivor benefits, as this may change the amount of your award. If you notify the VCF within 90 days of learning of the new collateral source payment, your award will not be adjusted to reflect the new entitlement or payment. If you notify the VCF more than 90 days after learning of the new or revised entitlement or payment, the VCF may adjust your award to reflect the new payment as an offset, which may result in a lower award. If you need to notify the VCF of a new collateral source payment, please complete the "Collateral Offset Update Form" found under "Forms and Resources" on the www.vcf.gov website.

Your award was calculated using our published regulations, and I believe it is fair and reasonable under the requirements of the Reauthorized Zadroga Act. As always, I emphasize that no amount of money can alleviate the losses suffered on September 11, 2001.

If you have any questions, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund

cc: JOHN RAKIS



September 11th
Victim Compensation Fund

Award Detail

Claim Number: VCF0026520
Decedent Name: FREDDIE WALLACE-RAKIS

PERSONAL INJURY CLAIM (Losses up to Date of Death)	
Lost Earnings and Benefits	
Loss of Earnings including Benefits and Pension	
Mitigating or Residual Earnings	
Total Lost Earnings and Benefits	\$0.00
Offsets Applicable to Lost Earnings and Benefits	
Disability Pension	
Social Security Disability Benefits	
Workers Compensation Disability Benefits	
Disability Insurance	
Other Offsets related to Earnings	
Total Offsets Applicable to Lost Earnings	\$0.00
Total Lost Earnings and Benefits Awarded	\$0.00
Other Economic Losses	
Medical Expense Loss	
Replacement Services	
Total Other Economic Losses	\$0.00
Total Economic Loss	\$0.00
Total Non-Economic Loss	\$250,000.00
Subtotal Award for Personal Injury Claim	\$250,000.00



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DECEASED CLAIM (Losses from Date of Death)	
Loss of Earnings including Benefits and Pension	
Offsets Applicable to Lost Earnings and Benefits	
Survivor Pension	
SSA Survivor Benefits	
Worker's Compensation Death Benefits	
Other Offsets related to Earnings	
Total Offsets Applicable to Loss of Earnings and Benefits	\$0.00
Total Lost Earnings and Benefits Awarded	\$0.00
Other Economic Losses	
Replacement Services	
Burial Costs	\$20,705.00
Total Other Economic Losses	\$20,705.00
Total Economic Loss	\$20,705.00
Non-Economic Loss	
Non-Economic Loss - Decedent	\$250,000.00
Non-Economic Loss - Dependent(s)	\$100,000.00
Total Non-Economic Loss	\$350,000.00
Additional Offsets	
Social Security Death Benefits	(\$255.00)
Life Insurance	(\$61,254.89)
Other Offsets	(\$96,444.92)
Total Additional Offsets	(\$157,954.81)
Subtotal Award for Deceased Claim	\$212,750.19



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Subtotal of Personal Injury and Deceased Claims	\$462,750.19
PSOB Offset	
Prior Lawsuit Settlement Offset	
Previously Paid Personal Injury Award	
TOTAL AWARD	\$462,750.19
Factors Underlying Economic Loss Calculation	
Annual Earnings Basis (without benefits)	
Percentage of Disability attributed to Eligible Conditions - applicable to Personal Injury losses	
Start Date of Loss of Earnings Due to Disability - applicable to Personal Injury losses	

Eligible Conditions Considered in Award
Acute Myelogenous Leukemia



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Treating Physician Information Form

Treating Physician Information Form

Name of Patient: Freddie Wallace-Rakis

VCF Claim Number: VCF 0026520

Physician Name: Elpidio Jimenez, M.D.

In the below chart, list the conditions for which you are currently treating (or previously treated) the Claimant. For each condition, provide the earliest date (month and year) of symptom onset and the date of first diagnosis (month and year).

Please provide copies of relevant records to support the diagnoses for the conditions listed below and any other information that might be relevant to the VCF, such as the effect of the condition(s) on the Claimant. As an alternative to providing supporting medical records, you may instead provide a written report explaining your diagnosis and its basis, along with your recommendation for treatment and management.

If applicable, please also provide a summary of any complications of treatment (i.e., new diagnoses stemming from treatment) and provide applicable medical records.

Condition Treated	Earliest Date of Symptom Onset (month/year)	Date of First Diagnosis (month/year)
Acute Leukemia		12/31/12



FREDDIE WALLACE-RAKIS

DOB: [REDACTED]

12:00:00AM

MR#: [REDACTED]

EKG 12 lead EKG[Reference:EEKG6755651]<Kristie Busch DO Dec 27 2012 4:57PM>

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PMD Dr Lwin [Reference:CPMD6755651]<Kristie Busch DO Dec 27 2012 5:32PM>

ORDERED BY LAB

Urine Microscopic[Reference:SQH270681UMIC]<BUSCH, KRISTIE A Dec 27 2012 6:45PM>



FREDDIE WALLACE-RAKIS	DOB:	[REDACTED]	12:00:00AM	MR#:	[REDACTED]
Results	[REDACTED]				

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BASERecover

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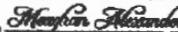
MICRO Tests Results Date Jan 2 2013 5:14PM	Test Blood Culture	Order Date
Blood Culture - Spec. Descr. BLOOD		
Blood Culture Gram Stain gram positive cocci in pairs and chains in the anaerobic bottle.		
Blood Culture Culture Enterococcus faecium For susceptibility results, see order W286068		
Blood Culture BETH ISRAEL PETRIE DIV FIRST AVE AT 16TH ST., NEW YORK, NEW YORK 10003		
Blood Culture Report Status 01/05/2013 Final		
MICRO Tests Results Date Jan 2 2013 5:18PM	Test Blood Culture	Order Date
Blood Culture - Spec. Descr. BLOOD		
Blood Culture Gram Stain gram positive cocci in pairs and chains in the anaerobic bottle.		
Blood Culture Culture Enterococcus faecium		
Blood Culture BETH ISRAEL PETRIE DIV FIRST AVE AT 16TH ST., NEW YORK, NEW YORK 10003		
Blood Culture - Report Status 01/05/2013 Final		
SUSCEPTIBILITY		
Blood Culture ORGANISM Enterococcus faecium		
Blood Culture - METHOD MIC (mcg/mL)		
Blood Culture - Ampicillin >=32 Resistant		
Blood Culture - Erythromycin >=8 Resistant		
Blood Culture - HLR Gentamicin Susceptible		
Blood Culture - Levofloxacin >=8 Resistant		
Blood Culture - Linezolid 2 Susceptible		
Blood Culture - Nifurofentolin 04 Intermediate		
Blood Culture - Quinupristin/dalf 0.5 Susceptible		
Blood Culture - HLR Streptomycin Resistant		
Blood Culture - Tetracycline >=16 Resistant		
Blood Culture - Vancenomycin >=32 Resistant		
Blood Culture Vancenomycin Resistant Enterococcus Your patient has a multiplying resistant organism and needs to be on contact precautions. Please call Infection Control if you have any questions.		
Blood Culture - Ciprofloxacin >=8 Resistant		
Blood Culture - Penicillin G >=64 Resistant		
Blood Culture - Tipecycline <=0.12 Susceptible		
Pathology Tests Results Date Dec 31 2012 3:36PM	Test PATH	Order Date 12/31/2012
PATH CASE: LS12-12095		
PATH PATIENT: FREDIE WALLACE-RAKIS		
PATH TISSUE SUBMITTED: A. BONE MARROW CORE BX		
PATH B. BONE MARROW CLOT BX		
PATH C. 1 SMEAR		
PATH FINDINGS:		
PATH A, B, and C. Bone marrow core biopsy, clot and smear:		
PATH Acute myelogenous leukemia.		
PATH Favus acute monocytic leukemia.		
PATH Note: bone marrow biopsy and clot show markedly hypercellular bone marrow with marked increase in the number of nucleated cells to be blast forms and promonocytes.		
PATH The flow cytometry analysis of peripheral blood performed at Integrated PATH Oncology was reported as showing approx. 20% myeloblasts. The myeloblasts show the following phenotype: positive for CD13, CD33, CD34, CD117, HLA-DR, CD11c PATH and CD14. An increased number of CD14+/CD64+ monocytes (~15% of total) were also reported.		
PATH CLINICAL HISTORY:		
PATH Acute leukemia		
PATH GROSS:		
PATH A. The specimen is received in formalin and labeled "Bone Marrow Biopsy". It consists of a 1.0 x 0.2 cm core of tan-red bone tissue. Entirely submitted in one cassette.		
PATH B. The specimen is received in formalin and labeled "Bone Marrow Clot". It consists of a 2.2 x 1.8 x 0.2 cm aggregate of blood clots. Entirely submitted in one cassette.		
PATH C. The specimen consists of one bone marrow smear. The slide is sent to PATH Hematology for staining.		
PATH Dictated by G2.		
PATH The electronic signature indicates that the named Attending Pathologist has evaluated the specimen referred to in the signed section of the report and formulated the diagnosis therein.		
PATH Electronically signed by Elpidio Jimenez, M.D. 12/31/2012 3:34:52PM		
Radiology Tests Results Date Dec 27 2012 5:20PM	Test Xray Chest (PA/Lat)	Order Date 12/27/2012
Xray Chest (PA/Lat)	I, Ira Reznick, M.D., have personally reviewed the images and concur with the preliminary report below. This report now represents the FINAL REPORT for this patient.	
Xray Chest (PA/Lat)	

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Mar 28 2017 12:53PM HP LASERJET FAX

Page 1

**DATE FILED THE CITY OF NEW YORK - DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH Certificate No.**

Place of Death		Date and Time of Death		Time, Month, Year		Place, Middle, Last	
State	City, Borough	2a. Type of Death	2b. Place of Death	2c. Date of Death	2d. Time of Death	2e. Room No.	2f. Name, Middle, Last
		1 C Hospital Inpatient 2 C Emergency Dept./Ambulance 3 C Died on Ambulance	4 C Hospital Discharge 5 C Death Facility 6 C Death Facility	January 03, 2018	06:42 AM	308	John Raldis
		7 C Other Specify					University Hospital Emergency Room Brooklyn, New York
2g. Condition: I certify that deceased was in the best, clear and concise language, and that to the best of my knowledge accurate before or following CDR NOT play any part in certifying death, and that deceased was not a member of my family and was due entirely to NATURAL CAUSES. This information is on reverse of certificate.							
Name of Physician		Signature		SSN		Signature Electronically Authorized	
Michael Alexander MD				00-00000000		JAN-03-2018	
Address		Name or Name		License No.		Date	
339 Hicks Street, Brooklyn, New York 11201				106457		JAN-03-2018	
Anatomical State/Specimen		2b. County		2b. City or Town		2d. Street and Number	
New York		Kings		Brooklyn		215 Adams Street	
3a. Date of Birth		(Month) (Year)		3b. Age at last birthday		Appt. No.	
				(Years)		SSN	
				67		11201	
3c. Sex		3d. Month		3e. Days		3f. Initials	
Male		March		3		S.J.	
Female		April		4		M.J.	
3g. Household Composition		3h. Household Relation to Deceased		3i. Household Relation to Deceased		3j. Household Relation to Deceased	
Executive Assistant		Spouse		Son		Daughter	
11. Residence (City & State or Foreign Country)		12. Relationship to Deceased		13. Relationship to Deceased		14. Relationship to Deceased	
New York, New York		Spouse		Son		Daughter	
15. Employer (U.S. Army Forces?)		16. Household Members (Name, Blood Relationship, Age)		17. Household Members (Name, Blood Relationship, Age)		18. Household Members (Name, Blood Relationship, Age)	
Army Forces?		16. Household Members (Name, Blood Relationship, Age)		17. Household Members (Name, Blood Relationship, Age)		18. Household Members (Name, Blood Relationship, Age)	
1 C No 2 C Yes		1 C Spouse, Mother, Father 2 C Son, Daughter, Grandchild 3 C Grandparent, Parent or Relative 4 C Friend, but separated 5 C Other,Specify		1 C Spouse, Mother, Father 2 C Son, Daughter, Grandchild 3 C Grandparent, Parent or Relative 4 C Friend, but separated 5 C Other,Specify		1 C Spouse, Mother, Father 2 C Son, Daughter, Grandchild 3 C Grandparent, Parent or Relative 4 C Friend, but separated 5 C Other,Specify	
19. Father's Name (First, Middle, Last)		20. Mother's Name (First, Middle, Last)		21. Spouse's Name (First, Middle, Last)		22. Next of Kin (Name, City, State)	
Percy Wallace		Naomi Hewitt		John Raldis		John Raldis	
23. Informant's Name		24. Relationship to Deceased		25. Address (Street and Number)		26. City & State	
John Raldis		Spouse		215 Adams Street, Brooklyn, New York		11201	
27a. Method of Disposition		27b. Disposition (Check all that apply)		28a. Method of Disposition		28b. Disposition (Check all that apply)	
1 C Burial 2 C Cremation		3 C Burial 4 C Cremation		1 C Burial 2 C Cremation		3 C Burial 4 C Cremation	
5 C Other, Specify							
29a. Location of Disposition (City & State or Foreign Country)		29b. Date of Disposition		30a. Address (Street and Number)		30b. City & State	
Brooklyn, New York		mm dd yyyy		171 Court Street, Brooklyn, New York		11201	
31a. Parent Establishment		31b. ZIP Code					
Cobble Hill Chapels							

**THE CITY OF NEW YORK - DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CONFIDENTIAL MEDICAL REPORT**

VITAE MEDICAL INFORMATION		CONFIDENTIAL MEDICAL REPORT		
		To be filled in by FUNERAL DIRECTOR or, in case of City Burial, by Physician		
21. CAUSE OF DEATH Description of disease or condition leading to death <small>Supplementary information, if any, concerning the cause of death such as a transfer from another hospital or a report from the medical examiner investigating the cause of death</small>		Certificate No. (Signature) 21. Place of death by the U.S. Census (Check one or more to indicate where the deceased resided or resided in day) <input type="checkbox"/> 1A Hospital <input checked="" type="checkbox"/> 1B Black or African American <input type="checkbox"/> 1C American Indian or Alaska Native <small>(check all that apply)</small> <input type="checkbox"/> 1D Other indoor location <input type="checkbox"/> 1E Other <input type="checkbox"/> 1F Chinese <input type="checkbox"/> 1G Japanese <input type="checkbox"/> 1H Vietnamese <input type="checkbox"/> 1I Korean <input type="checkbox"/> 1J Vietnamese <input type="checkbox"/> 1K Other Asian-Specify <input type="checkbox"/> 1L European <input type="checkbox"/> 1M German or otherwise <input type="checkbox"/> 1N Hispanic <input type="checkbox"/> 1O Other <input type="checkbox"/> 1P Other-Specify Specify _____		
22. CAUSE OF DEATH - List only one cause on each line. DO NOT ASSEMBLE.		FREDDIE WALLACE RAADS DECEDENT'S LEGAL NAME (Type or Print)		
a. IMMEDIATE CAUSE ACUTE LEARNERIES b. DUE TO OR AS A CONSEQUENCE OF		APPROXIMATE TIME OF DEATH MONTH		
c. DUE TO OR AS A CONSEQUENCE OF				
d. DUE TO OR AS A CONSEQUENCE OF				
e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND ASSOCIATED WITH THE UNDERLYING CAUSE given in Part I. Include operation histories. Renal Failure Hypertension				
f. Was an autopsy performed? 1) Yes 2) No 3) Partially		g. If Yes, within how long of death? 1) Within 24 hours 2) Within 1 week 3) Within month 4) Within year 5) After removal of heart 6) After removal of brain 7) After removal of heart & lung 8) After removal of heart & lungs 9) After removal of heart & lungs & liver 10) After removal of heart & lungs & liver & kidneys 11) After removal of heart & lungs & liver & kidneys & spleen 12) After removal of heart & lungs & liver & kidneys & spleen & brain		
h. Was an autopsy requested? 1) Yes 2) No 3) Partially		i. Postmortem within one year of death, outcome of pregnancy 1) Still birth 2) Spontaneous Termination 3) Induced Termination 4) None		
j. Did the deceased give birth within one year of death? 1) Yes 2) No		k. Date of Outcome mm dd yyyy		
l. Was this note referred to OCM? 1) Yes 2) No				
m. Did the deceased die in a hospital or other place of care? 1) Yes 2) No 3) Partially 4) Not known				
n. I am certifying to my knowledge and belief the cause of death. <i>Moshe C. Raads</i> M.D.		ADDRESS 339 Hicks Street, Brooklyn, New York 11201 LICENSE NO. 105457		